MONTANA
FAMILY PLANNING PROJECT

1115(a) DEMONSTRATION WAIVER APPLICATION

A PROPOSAL TO REDUCE UNINTENDED PREGNANCIES AND IMPROVE THE WELL-BEING OF MONTANA CHILDREN AND FAMILIES

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
HEALTH RESOURCES DIVISION

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Montana Family Planning Project
Section 1115(a) Demonstration Waiver Application

Contents

I. Montana's Proposal

The Montana Family Planning Project (MFPP) will expand access to family planning services by providing Medicaid family planning services to Montana female residents up to 50 years old with income at or below 185 percent of the federal poverty level (FPL).

If women in this eligibility group become pregnant now, they will likely be eligible for Medicaid, as unborn children increase family size. In addition, the project will extend Medicaid eligibility for family planning services postpartum for women who would have otherwise lost eligibility. Increasing the spacing of births will reduce the number of future births supported by Medicaid and the resultant infant health care costs, since most infants retain eligibility to one year of age.

Although these savings alone would make the project cost-effective, savings also may be realized in the Temporary Assistance for Needy Family (TANF) program by helping women to avoid mistimed (the woman wanted to be pregnant later) or unwanted (the woman did not ever want to be pregnant) pregnancies. Public health is also projected to improve with a concomitant benefit from a decrease in the rate of sexually transmitted diseases as a result of early detection and treatment during family planning visits.

A. Introduction

The Institute of Medicine's report, *The Best Intention: Unintended Pregnancy and the Well-being of Children and Families* states:

> All pregnancies should be intended – that is, they should be consciously and clearly desired at the time of conception.[1]

The MFPP aims toward this goal. Expansion of family planning services will reduce the number of unintended pregnancies among low-income women currently unable to afford counseling, contraception, and services.

Unintended pregnancies are defined as those reported by women as unwanted or mistimed. Nationally, almost 49 percent of pregnancies are estimated to be unintended, while in Montana, approximately 64 percent of pregnancies are unintended.[2] In addition, short child spacing intervals (also referred to as interbirths or inter-pregnancy intervals) have been associated with low birth weight, preterm delivery, and delivery of a small-for-gestational-age infant.[3]

A study by the National Poverty Center found income-based Medicaid family planning waivers increased the number of women receiving family planning services through Medicaid by two to three times. The study reported the results of models for teens and non-teens, which showed that income-based waivers reduced births by 1.7 to 2 percent for non-teens and 4.2 to 4.7 percent for

[1] The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families. Sarah Brown and Leon Eisenburg. National Academy Press, 1995

[2] Montana Statewide Title X Family Planning program data, 1991-2005.

[3] Olof Stephansson, MD, PhD, Paul W. Dickman, PhD, and Sven Cnattingius, MD, PhD. "The Influence of Interpregnancy Interval on the Subsequent Risk of Stillbirth and Early Neonatal Death." Obstetrics & Gynecology. July 2003. Volume 102, Number 1. Page 101-108.

teens. Incorporating information on predicted increases in eligibility brought about by state income-based waiver policies, the study estimated that births fell by 8.9 percent among newly-eligible women ages 20 through 44. The study documented that this impact can be attributed to increased contraceptive use among sexually active women.[4]

B. Environment

1. Unintended Pregnancy, a National Problem

Nationally, 74 percent of pregnancies to women with family incomes of less than 150 percent FPL are unplanned with low-income women of color at the highest risk of unintended pregnancies.

Because the risk of pregnancy is so great in the absence of contraception, almost 50 percent of unintended pregnancies occur to the very small percentage (10 percent) of women who are sexually active but not using contraception.[5] Most unintended pregnancies among women who do use contraception result from inconsistent or incorrect use. Low income women have higher contraceptive failure rates than higher-income women.

Teens have a particularly high rate of unintended pregnancy. Nationally, more than 80 percent of teen pregnancies are unintended.[6]

While family planning services for men could play a pivotal role in the prevention of unintended pregnancy, few pregnancy prevention initiatives or programs target men or provide adequate funding for full program development and operation. In the first experience with intercourse, 67 percent of men rely on condoms. By their late 20s, 45 percent of men rely on their partners to use a female contraceptive method.[7] During their late 30s, 15 to 20 percent of men and women rely on vasectomies for contraception.[8] As a contraceptive, a vasectomy is among the most effective and economical methods. However, also during the late 30s, female methods provide the preponderance of protection against unintended pregnancies: 24 percent of men and 31 percent of women rely on female sterilization, and 21 percent of men and 14 percent of women rely on other female methods.[9]

2. Unintended Pregnancy, a Montana Problem.

In Montana, 78 percent of family planning patients receiving positive pregnancy test results self-reported that their pregnancies were unplanned.[10] There are 55,010 women in need of publicly funded contraceptive services and supplies. 42,210 of these women are below 250 percent FPL

[4] Kearney, Melissa S. and Phillip B. Levine, "Subsidized Contraception, Fertility, and Sexual Behavior," National Poverty Center Working Paper Series, #07-11, April 2007.
[5] The Alan Guttmacher Institute: www.guttmacher.org
[6] The Alan Guttmacher Institute: Sexual and Reproductive Health; Men and Women 2002
[7] The Alan Guttmacher Institute: www.guttmacher.org
[8] The Alan Guttmacher Institute: Sexual and Reproductive Health; Men and Women 2002
9 The Alan Guttmacher Institute: Contraception Counts: Montana 2006
[10] Montana Statewide Title X Family Planning program data, 2006. Denominator is number positive pregnancy tests (1,157), numerator is number of positive pregnancy tests where client reported pregnancy was unplanned (905).

and 12,800 are sexually active teenagers.[11] An estimated 33 percent of Montana females between the ages of 19 and 25 are uninsured. Twenty-four percent of Montanans between the ages of 26 and 49 are uninsured.[12]

Montana teenage pregnancy rates rank 38th nationally.[13] The five year average teen pregnancy rate for Montana residents 15 through 19 years of age was 50 pregnancies per 1,000 population.[14] Of these, 73.5 percent resulted in live births; 26.2 percent resulted in induced abortions. Though teen pregnancy rates in Montana are below the national average, the pregnancy rate for Montana teens aged 15 to 19 decreased only 6.5 percent between 1996 and 2005.[15]

3. Consequences of Unintended Pregnancy

Unintended pregnancy adversely impacts the health and well-being of Montana women and the public's efforts to reform health and welfare systems. The public welfare system cannot meet its goal of helping families achieve self-sufficiency without addressing the challenges and public costs of unintended pregnancies. Welfare reform has increased pressure on Temporary Assistance for Needy Families (TANF) clients to become self-sufficient. The lives of TANF clients and their families may be adversely complicated by unintended or mistimed pregnancies.

Because women whose pregnancies are unintended are likely to discover their pregnancies later than those with intended pregnancies, they are less likely to adopt healthy behaviors and start prenatal care at the beginning of pregnancy.[16] For example, women with mistimed or unwanted pregnancies are more likely to smoke cigarettes and less likely to follow their doctor's advice to quit smoking than women with intended pregnancies.[17] Smoking during pregnancy not only negatively affects the mother's health but also can result in preterm delivery and low infant birth weight.[18] In addition, women with unintended pregnancies may have had inadequate pre-pregnancy folic acid intake, which has been linked with neural tube defects.[19] Unintended pregnancy can also affect infant and child health after delivery. For example, mothers with unintended pregnancies resulting in live births are less likely to breastfeed their infants than women with intended pregnancies.[20]

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[11] http://www.guttmacher.org/pubs/win/win2004.pdf

[12] Montana State Planning Grant, August 2004. http://www.dphhs.mt.gov/publications/stateplanninggrant.pdf. Figures were stratified by gender by request.

[13] The Alan Guttmacher Institute (2004) *U.S. teenage pregnancy statistics: Overall trend, trends by race and ethnicity and state-by-state information.* www.guttnacher.org/pubs/state_pregnancy_trends.pdf.

[14] Montana Department of Public Health and Human Services, Vital Records Services Bureau.

[15] Vital Records, using 3 year rolling averages with 1996 to 1998 equal to 53.2 per 1,000 and 2003 to 2005 equal to 49.7 per 1,000.

[16] Kost, K, D.J. Landry, and J.E. Darroch. "Predicting Maternal Behaviors During Pregnancy: Does Intention Status Matter?" *Family Planning Perspectives*, 30(2), 1998, 78-88.

[17] Hellerstedt, W.L., *et al*, "Differences In Preconceptional and Prenatal Behaviors in Women with Intended and Unintended Pregnancies," *American Journal of Public Health*, 88(4), 1998, 663-666.

[18] Mainous, A.G. and W. J. Hueston. "The Effect of Smoking Cessation During Pregnancy on Preterm Delivery and Low Birth Weight", *The Journal of Family Practice*, 38(3), 1994, 262-266.

[19] Locksmith, G.J and P. Duff, "Preventing Neural Tube Defects: The Importance of Periconceptional Folic Acid Supplements," *Obstetrics and Gynecology*, 91, 1998, 1027-1034.

[20] Dye, T., *et al*. "Unintended Pregnancy and Breast-feeding Bahavior." *American Journal of Public Health*, 87(10), 1997, 1709-1711.

Teen pregnancy and child rearing have economic and social costs that affect generations. Making additional progress in reducing teen pregnancy will benefit national and state economies and improve the educational, health, and social prospects for this and later generations. Teen mothers are more likely to drop out of school, remain unmarried, and live in poverty. Only 40 percent of teen mothers graduate from high school compared to 60 percent of mothers who gave birth at 20 years. Young mothers earn $3,350 less per year than mothers who gave birth at 20 years. This gap increases to a difference of $11,000 per year by age 30.[21]

Children of teen mothers are more likely to be born at low birth weight, grow up poor, live in single parent homes, experience abuse and neglect, and enter the child welfare system. Girls born to teen mothers are more likely to become teen mothers themselves—up to three times more likely than girls born to non-teen mothers. Sons of teen mothers are more likely to be incarcerated—nearly 14 percent of sons born to mothers age 17 and younger will be in prison by their late 30s, compared to six percent of sons born to mothers age 20.[22]

Table 1 and Figures 1 and 2 show the overall birth trends in Montana from 2001 through 2005. As shown, approximately one third of all Montana births are funded by Medicaid. For teen births, this figure increases to approximately one half.

Table 1: Birth data for Montana and Montana Medicaid from 2001 to 2005

Year	All births	Medicaid births	Medicaid as % of total births	All teen births	Medicaid teen births	Medicaid as % of total teen births
2001	10,947	3,370	31%	1,266	502	40%
2002	11,045	4,003	36%	1,277	664	52%
2003	11,384	3,999	35%	1,211	601	50%
2004	11,514	4,179	36%	1,225	630	51%
2005	11,556	4,218	37%	1,201	650	54%

[21] By the Numbers: The cost of teen child rearing. www.teenpregnancy.org.costs
[22] Ibid

Figure 1: Total Montana Births and Montana Medicaid Births

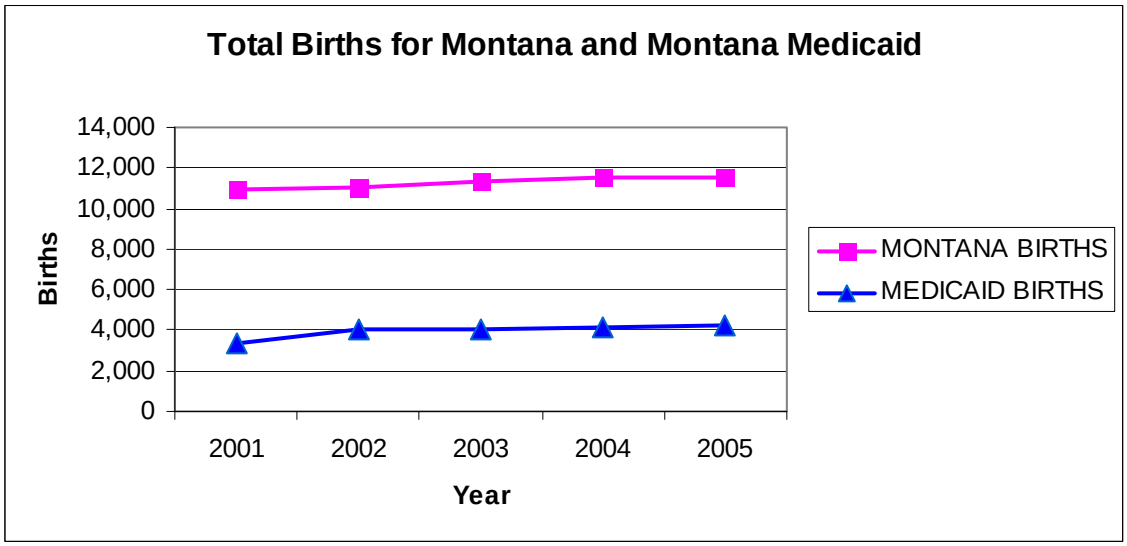
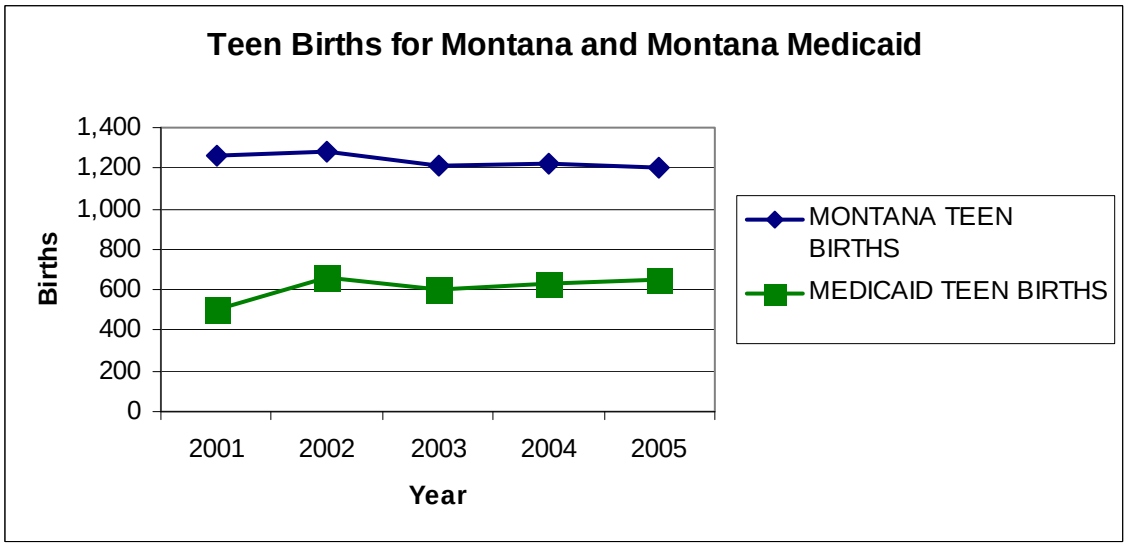


Figure 2: Teen Births for Montana and Montana Medicaid



4. Sexually Transmitted Infections in Montana

Prevention of sexually transmitted infections (STI), particularly among youth, deserves greater attention in the overall effort to improve Montana's health and well being. In Montana in 2006, the Chlamydia rate for all ages was 293.6 per 100,000 people and the gonorrhea rate for all ages was 21 per 100,000 people. There were 940 reported cases of Chlamydia for people under 20 years old, representing 36 percent of total cases. There were 50 reported cases of gonorrhea, representing 27 percent of all cases. Montanans under age 25 represented 76 percent of all reported cases of Chlamydia and gonorrhea in 2006. 735 cases of HIV infection were reported

through December 2006, including 16 cases among those ages 0 through 19 years. This age group has a high need for sexual health services.

5. Conclusion

The primary goal of MFPP is to increase the number of intended pregnancies, through expanded coverage of family planning services for women with incomes at or below 185 percent FPL, avoiding increased pregnancy-related monetary and social costs. The MFPP will expand outreach and education for family planning services.

Coverage of family planning services for women is an important, cost-saving strategy for reducing unintended pregnancies, including teen pregnancies. National studies have demonstrated that for every dollar spent on subsidized family planning services, an average $4.40 will be saved in public dollars annually on medical, financial assistance, and nutritional services.[23] Increased access to family planning services will promote increased reproductive health services, including prevention, diagnosis and treatment of STIs. Overcoming the financial and personal barriers to accessing contraceptive services is critical to reducing unintended pregnancies and preventing STIs. The MFPP will be an important step in this direction.

C. Montana's Current System

1. Medicaid

Montana Medicaid is authorized under 53-6-101, Montana Code Annotated and Article XII, Section 3 of the Montana Constitution. Montana Medicaid pays the costs for medically necessary health care for clients who demonstrate financial and medical need. The state administers Medicaid and is responsible for determining eligibility for clients and paying providers for covered services.

Medicaid services are funded by a federally determined formula that combines state and federal revenues. Currently Montana pays approximately 31 cents of every Medicaid dollar spent; the federal government pays the remaining 69 cents.

Categorically needy clients are Medicaid eligible under federally defined groups and have family incomes and resources below the limit for their categories. Medically needy clients generally have critical and/or very costly medical conditions. To qualify for Medicaid, the medically needy client must meet resource limit restrictions and incur a specified amount of medical bills each month.

Montana Medicaid includes coverage of all federally defined mandatory services, including family planning.

2. Basic Medicaid

Under Montana Medicaid, qualified adults ages 21 to 64 who are not pregnant or disabled can receive a limited package of Medicaid-reimbursed services. Individuals who are served under

[23] "Adding It Up: The MEDICAL Benefits of Investing in Sexual and Reproductive Health Care" and "Adding It Up: The NON-MEDICAL Benefits of Investing in Sexual and Reproductive Health Care." The Alan Guttmacher Institute. 2003.

Basic Medicaid are adult clients who are eligible because they meet the Medicaid eligibility criteria under Section 1931 or Section 1925 of the Social Security Act or they are the specified caretaker relative of a dependent child.

Basic Medicaid is a continuation of the state's welfare reform waiver, Families Achieving Independence in Montana (FAIM). The FAIM waiver was in effect from February 1, 1996 and expired on January 31, 2004. Montana submitted and was subsequently approved for an 1115 Waiver in 2004 to continue the Basic Medicaid coverage of individuals who qualify for limited services established through the FAIM program.

Basic Medicaid also covers family planning services.

Current Medicaid rules provide coverage to pregnant women at or below 150 percent FPL. Women are eligible for Medicaid benefits following the confirmation of pregnancy and continuing through 60 days postpartum. After 60 days, women who do not meet Medicaid's more stringent financial criteria for participation lose all services, including family planning. The lack of family planning services increases the risk of subsequent pregnancies less than two years apart.

3. Children's Health Insurance Plan (CHIP)

Children and youth with family incomes of 175 percent or less are eligible for health care coverage with CHIP, including family planning services. However, under Montana statute, CHIP does not cover birth control contraceptives.

D. Family Planning Demonstration Waiver Development

Montana has a long history of providing assistance to its neediest citizens, and has often worked in partnership with federal agencies to do so. The MFPP follows naturally in this tradition. Montana seeks to work with the Centers for Medicare & Medicaid Services, through the vehicle of a Section 1115 waiver, to provide high-quality family planning services to Montanans who need them and to reduce the overall costs of publicly funded family planning and maternity-related services.

1. State Experiences with Section 1115 Waivers.

In 1996 under the authority of a Section 1115 welfare reform waiver referred to as Families Achieving Independence in Montana (FAIM), Montana implemented a limited Medicaid benefit package of optional services to the same group of adults eligible for Medicaid under Section 1925 or 1931 of the Social Security Act (the individuals were ages 21 to 64, not pregnant and not disabled). The limited Medicaid benefit package has continued as the Basic Medicaid program. The FAIM welfare reform waiver expired January 31, 2004. The replacement 1115 waiver was approved effective February 1, 2004, continuing basic Medicaid coverage for able-bodied adults ages 21 to 64 who are not disabled or pregnant and who are eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act.

2. Legislation

In April 2005, the Montana Legislature enacted Senate Bill 110, a law "providing authority for the establishment of health insurance flexibility and accountability demonstration initiatives and

other demonstration projects upon approval of waiver of federal law." Specifically, Senate Bill 110 allowed that "The categories of persons that the department may consider for establishment as a Section 1115 waiver eligibility group include but are not limited to:

> …other specific groups of persons who are participants in programs or services funded solely or primarily through state general funds or who the department determines are in need of specific types of health care and related services, such as prescription drugs, reproductive health care, and mental health services, and are without adequate financial means to procure health insurance coverage of those needs.

During the 2007 Legislative Session, the Montana Legislature affirmed its commitment to expanding family planning services by allocating $348,297 of state one-time-only fund in preparation for the planning and implementation phases of an approved family planning waiver.

Montana's 2007 Legislature also expanded Medicaid coverage for pregnant women to 150 percent FPL (from 133 percent FPL). This waiver proposal's budget neutrality worksheet reflects the higher projected pregnancy and delivery costs and first year costs for newborns.

II. Administration

A. Administration Agency

Montana's Department of Public Health and Human Services, the state agency responsible for providing health care coverage for over 83,000 Medicaid clients along with other health care programs in the state of Montana, will implement the MFPP through its Health Resources Division, ensuring coordination with existing public health care programs and family planning efforts. Medicaid is managed through eight divisions of DPHHS. The Health Resources Division administers acute, primary, and preventive Medicaid services and SCHIP.

Attachment A includes an Organization Chart for the DPHHS Health Resources Division.

B. Program Oversight

Program oversight for the proposed waiver group will be included in activities currently provided by Montana Medicaid. The same CMS-approved quality assurance methods and oversight will be used for this waiver including:

1. Quality Assurance Division

The Quality Assurance Division of DPHHS ensures the accountability, integrity, and efficiency of Montana Medicaid through internal audits, investigations, and evaluations. This Division also follows up on complaints to identify Medicaid providers and clients who may be abusing the program.

2. Business and Financial Services Division

The Business and Financial Services Division provides financial and accounting oversight, cash management, preparation and filing of federal financial reports, and external audit coordination. In addition, this Division provides leadership and guidance in the development and implementation of accounting policies and procedures and best business practices.

III. Eligibility

A. Target Population

The MFPP will expand Medicaid coverage for family planning services to all Montana women with family incomes of 185 percent FPL and below who are under age 50 who are not otherwise eligible for Medicaid and who have no family planning health care coverage. This target population includes women who lost Medicaid coverage eligibility 60 days postpartum or post loss of pregnancy.

The MFPP plans to serve approximately 4,000 clients. Evaluations to increase, decrease, or maintain enrollment will occur every six months. Medicaid will implement a separate eligibility category for MFPP clients.

B. Eligibility Determination

The application and enrollment process is designed to reduce enrollment barriers and make family planning services available to eligible women in a timely manner.

Current Montana female residents up to age 50 who are at or below 185 percent FPL qualify. There will be no asset test for eligibility. The eligibility application will be a simple form with self-reported household income. The form will require family size but no family member information (other than for the applicant) and no income documentation. Applicants will furnish proof of U.S. citizenship in accordance with CMS guidelines and Montana Medicaid policy.

Women in the target population losing Medicaid eligibility at the end of the 60 day postpartum or post loss of pregnancy period will receive a written notice from Medicaid informing them of their termination of full Medicaid coverage and their continued eligibility for family planning services. This notice will be accompanied by an explanation of the family planning services covered under the Montana Family Planning Project. Those in the target population losing Medicaid eligibility for any other reason also will receive a written notice of their continued eligibility for family planning services.

Women may apply for the MFPP at providers' offices, through clinics, advocate facilities, online, or through Montana DPHHS. Providers will be supplied with MFPP applications, receive instructions for use and make presumptive eligibility determinations to provide services. Applications will be forwarded electronically to Montana DPPHS for final determination. Applications will be available via the department's website, by phone request, and at Offices of Public Assistance (OPAs).

The MFPP will provide services based on a presumptive eligibility determination. All services will be paid from the date of application until final eligibility determination, which may be up to

60 days. Providers can check for presumptive eligibility by using Medicaid's eligibility verification systems.

Once women are determined eligible for MFPP by a new system purchased for this purpose, an interface with the Medicaid eligibility system will ensure MFPP presence in the Medicaid eligibility system and then through nightly interfaces to MMIS, the claims payment system.

Potential MFPP applicants will be screened to determine if they are potentially eligible for regular Medicaid or Montana CHIP. If potentially eligible, applicants will be referred to the respective program.

C. Eligibility Duration

Eligibility for female adult clients over the age of 19 will be redetermined annually based on the 185 percent FPL. Eligibility redetermination will be conducted using Medicaid procedures. Montana Family Planning Project clients will be notified of their eligibility status using Medicaid procedures. Eligibility status will also be evident in the MMIS eligibility verification systems.

D. Eligibility Quality Assurance

A quality assurance process will be used through the eligibility system on an annual basis to monitor accuracy of client eligibility status.

Evidence of US citizenship or legal alien status will be documented with each potential client of MFPP services using CMS guidelines and Montana Medicaid policy.

IV. Coverage

A. Covered Services

Clients in the MFPP will be eligible for the following services:

1. Contraceptive counseling and information
2. Contraceptive supplies, devices, implants, and prescriptions
3. Office visits, consultation, examination, and medical treatment related to family planning
4. Laboratory examinations and testing related to family planning
5. HIV, HSV, Hepatitis B & C, HPV, and other STI testing
6. Treatment of Chlamydia, Gonorrhea, and Syphilis infections in conjunction with a family planning encounter
7. Immunization against HPV

Attachment B lists procedure codes for services covered under the waiver.

V. Delivery System

A. Reimbursement Rates

Payment for family planning services provided to Montana Family Planning project clients will be based on the Montana Medicaid fee schedule and billed fee-for-service. Eligible individuals will not have cost-sharing responsibility (copayments) for covered services and supplies.

Claims for family planning services will be processed through the Montana Medicaid Management Information System (MMIS). Client eligibility status will be made available to providers via standard Medicaid procedures.

B. Service Delivery

Current Montana Medicaid clients receive health care through a fee-for-service delivery system. All clients have free choice of family planning providers and may obtain family planning services from any enrolled provider. Family planning service delivery to MFPP clients will mirror family planning service delivery to the current Medicaid population. MFPP will provide thorough training to enrolled providers regarding identifying MFPP clients and billing Medicaid for MFPP services.

VI. Access

A. Outreach and Education.

The goal of the MFPP is to expand access to family planning services by providing Medicaid family planning services to Montana female residents with incomes at or below 185 percent FPL.

Project implementation will include a targeted statewide public information campaign to increase awareness and utilization of the project in its initial roll-out. The public information campaign will include select print media and other outreach avenues as required by enrollment levels.

As is the case for all materials designed to inform Montana Medicaid applicants and clients, the information developed by the MFPP will be rated at no higher than a seventh grade reading level. Information developed by the MFPP will be culturally sensitive.

Two brochures will be created for applicants. One will be a MFPP brochure that explains the MFPP itself: a description of the project, a list of covered services, basic eligibility criteria and contact phone numbers. The second will be a MFPP referral brochure that has information about how to apply for other public supported programs, including primary health care services.

All women who apply for the MFPP will receive the MFPP and the MFPP referral brochures upon application. In addition, the MFPP brochure and application will be available on-line, in providers' offices, advocates' facilities, and other applicable clinics

B. Access to Primary Care

The MFPP will establish formal arrangements with community health care providers to provide primary care services to enrolled individuals for non-family planning health care needs. Non-family planning primary care services will be paid for by non-MFPP funding. Primary care

providers will be easily identified by using Montana Medicaid's current Passport Provider system. In addition, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health, and Indian Health Service facilities will also be identified and utilized.

C. Provider Education

Training on this project will be made available to all providers and they will be kept informed of project changes through provider updates that DPHHS sends periodically to all enrolled providers. Provider education will be proactive to increase the number of participating providers to meet the needs of clients.

VII. Quality

A. Grievance and Quality Control

As a client of federal financial assistance, Montana DPHHS does not exclude, deny benefits to, or otherwise discriminate against anyone on the basis of race, color, national origin, age, sex, handicap, political beliefs, religion, or disability. This includes admission, participation, or receipt of services or benefits of any of its programs, activities or employment, whether carried out by the Department, or through a contractor or other entity.

Clients in the MFPP will have access to the same complaint and grievance processes that clients in state Medicaid programs have, including the right to appeal a denial of MFPP eligibility and/or denial of payment for services, administrative reviews, and fair hearings.

The State will conduct annual reviews of the MFPP to assure that claims paid at enhanced federal participation represent services that, in fact, represent family planning services. If any discrepancies exist, immediate efforts will be made to resolve the problem(s).

B. Program Confidentiality

Family planning services provided under this waiver will comply with all HIPAA confidentiality requirements.

VIII. Financing Issues

A. Budget Neutrality Assumptions

The following are the parameters that were used for budget neutrality calculations:

1. Fertility Rate

For the purpose of this waiver, baseline fertility rates from four years prior to implementation of the MFPP will be used for comparison.

2. Waiver Participants

Waiver participants will come from the following populations:

a. Women who are at or below 185 percent FPL who are not currently enrolled clients of any Medicaid program

b. Enrolled Poverty Pregnant Women Medicaid clients whose eligibility will expire two months after giving birth

c. Medicaid clients who lose eligibility for other reasons

3. Medicaid Reimbursement for Pregnancy

The cost of Medicaid reimbursement for prenatal care, delivery, and postpartum care from SFY 2006 shall be used as baseline data and for extrapolating subsequent projected costs. These data were derived from the MMIS claims database.

4. Administrative Costs

Administrative costs include contract and systems changes to the eligibility, enrollment, and claims processing systems for the waiver program during the initial year of implementation, along with estimated costs for outreach and program evaluation for all five years of the MFPP. Each administrative cost category is listed separately.

5. Personnel

One FTE is dedicated to eligibility administration. A Medicaid program officer in the Medicaid Managed Care Bureau of the DPHHS Health Resources Division will assume program services administration responsibilities.

6. Assumptions for Five Year Budget Projections

a. A 5 percent growth in basic Medicaid family planning client numbers per year. This estimate was derived by determining the rate of growth for the Poverty Pregnant client deprivation code between SFY 2002 and SFY 2005 then extrapolating to the general population.
b. A 5 percent growth in per capita payment rates per year. This includes the 3 percent cost of living increase plus another 2 percent for medical costs inflation.
c. An increase of deliveries by 1.7 percent a year for Medicaid births without the MFPP. This estimate derived by extrapolating the average percentage of Medicaid birth increases between SFY2002 to SFY2005 to subsequent years.
d. A 1.5 percent reduction in births per 1,000 clients or 6 percent overall with 4,000 clients enrolled per year in the MFPP and subsequent first year costs per year of MFPP implementation, beginning the second year of implementation. A zero percent reduction during the initial year is assumed to account for length of pregnancy. In addition, an estimate of 3,000 clients of the MFPP is used for year one to account for the time needed for recruitment.
e. Regular federal medical assistance percentage (FMAP) of 68 percent.
f. Family Planning FMAP of 90 percent.
g. System changes FMAP of 75 percent.
h. The number of first year cost clients will be higher than delivery clients due to estimating multiple birth deliveries and new first year cost clients moving into Montana. As the ratio of first year cost clients to deliver clients for the baseline year of 2005 was 1.0085, this ratio was used for subsequent years of MFPP.

Attachment C displays specific calculations for budget neutrality. In addition to these estimates of direct savings, additional savings will be seen but are not estimated in the current analysis. These include savings in WIC, TANF, food stamps, and medical and mental health care of youth in years subsequent to first year costs.

7. Caseload and Financing

A. Caseload projections
Montana estimates it will have the following caseloads during the five years of this waiver:

Waiver Year One	3,000 waiver participants
Waiver Year Two	4,000 waiver participants
Waiver Year Three	4,000 waiver participants
Waiver Year Four	4,000 waiver participants
Waiver Year Five	4,000 waiver participants

B. Savings
Montana expects this waiver to be cost effective, efficient, and in keeping with the objectives of Montana Medicaid. In addition, the waiver is expected to be budget neutral by virtue of reductions in future Medicaid prenatal care, delivery, and newborn and infant care expenditures. The estimated savings are detailed in the Budget Neutrality Worksheet in Attachment C.

C. Program costs
Montana estimates the direct cost for family planning services under this waiver for the five years of the project will be:

Waiver Year One	$555.66 per participant
Waiver Year Two	$583.44 per participant
Waiver Year Three	$612.61 per participant
Waiver Year Four	$643.24 per participant
Waiver Year Five	$675.40 per participant

D. State matching funds
Montana will provide its share of matching funds to support this waiver at the rate of ten percent for direct family planning services.

IX. Systems Support
A new web based eligibility system will be purchased for determination of eligibility for MFPP. Claims and reporting for the MFPP will be managed through the Montana MMIS system. The MMIS system is capable of processing client eligibility, claims, and provider enrollment. A specific client deprivation code will be created for MFPP clients.

X. Implementation Time Frames

A. Involvement of Public Agencies and Advocates
In March of 2004, the State of Montana was approached by Working for Equality & Economic Liberation (WEEL), a statewide low-income advocacy group, to begin exploring the possibility of a Section 1115(a) demonstration waiver to extend family planning services to women and men at or below 200 percent of the federal poverty level. Low-income individuals who do not qualify for Medicaid programs are unlikely to have insurance coverage or sufficient personal funds to

purchase family planning and reproductive health services in the private sector. They are therefore at higher risk of unintended pregnancies and in need of family planning services.

In November 2004, the Department hosted a Family Planning Waiver meeting. This meeting was an opportunity for external stakeholders and interested parties to provide input to DPHHS efforts to design a Medicaid waiver that expands family planning services to low-income women at risk for unintended pregnancies.

In preparation for the 2005 state legislative session, state agency staff held informal discussions with current providers of subsidized family planning services and representatives of the various advocacy groups. Language that would create the family planning project was included in the Department's HIFA waiver bill for legislative consideration (Senate Bill 110).

The MFPP was presented to the Montana DPHHS Health Resources Division Administrator, DPHHS Director and Deputy Director, and was subsequently forwarded to the Governor's Office. DPHHS published official notice of a public meeting to receive comment on the waiver request to conduct a family planning demonstration in the Montana State Register. The notice included instructions on how to receive background information and materials. The notice was mailed to public health agencies, family planning providers, provider groups, and low-income advocates. The waiver proposal was posted on the DPHHS website and was open for a 60-day public comment period from _____ through _____, 2007.

In addition, written notice was sent to all Montana Tribal chairs and Tribal Health Directors 60 days before anticipated submission date of the MFPP waiver, in accordance with the federal requirement for adequate notice to American Indian tribes when states develop waiver requests. The tribal consultation requirements adopted by the State of Montana were followed during the development of the MFPP waiver. A record of all comments received through these processes was maintained. Health Resources Division staff compiled and provided responses to all comments on _____, 2007.

Specific Timeline Dates:

Waiver document completed	09/28/2007
Document approved by DPHHS Director and Deputy Director	10/12/2007
Document submitted to Governor's office	10/12/2007
Governor's office approval	11/05/2007
Draft document submitted to CMS for discussion	11/26/2007
Document available for public comment	11/26/2007
Document submitted to Tribes and GAIN Council for comment	through 01/25/2008
Responses to public, Tribal and GAIN Council comments	02/08/2008
Final document submitted to CMS	02/22/2008
CMS review, questions, responses	90 days
CMS approval received	05/22/2008
Program implementation	07/01/2008

XI. Evaluation and Reporting

A. Information about the Demonstration

The MFPP is targeted to begin in July 2008 and end June 2013. It is a new demonstration.

The MFPP will impact women of reproductive age who reside in Montana and whose household incomes are at or below 185 percent of the federal poverty guidelines and who do not otherwise have access to Medicaid

The requirement for the evaluation of the MFPP is that it assesses its goals toward improved health of clients. Elaboration on the goals, objectives, key interventions, and outcomes are delineated below.

The overall hypotheses of the MFPP is that effective outreach and enrollment of women of reproductive age who are at or under the 185 percent of federal poverty level into a family planning program, then providing them family planning services, will result in a decrease of unintended pregnancies, an overall improvement of clients' health, and savings to Montana Medicaid.

The MFPP Project Evaluation focuses on measures to ascertain the degree to which it achieved its purposes, goals, objectives and quantified performance targets. The project evaluation will clarify the lessons learned from the MFPP, opportunities for improvement, and how it affected clients, providers, and Montana Medicaid. From these assessments, feedback will be produced to allow ongoing modifications of MFPP to assure it meets its goals and objectives. In addition, the outcomes of the MFPP will be used for recommendations for other states' family planning programs.

The evaluation of the MFPP will be conducted by DPHHS. Implementation of the evaluation process will occur simultaneously with the implementation of the MFPP. Reports using CMS recommended guidelines will be made annually.

Project evaluation will be based on the goals and objectives listed below. The goals and objectives are centered on reducing the number of women who lack insurance for family planning services, improving their access to this health care need, the integrity of the MFPP, and its cost-effectiveness.

Measurements will be compared against figures from years prior to MFPP implementation using a pre/post intervention design. As the MFPP will be implemented statewide from its onset, quasi-experimental designs will not be conducted. The advantages and limitations of this design will be taken into account when analyzing data sets.

B. Evaluation Process

The evaluation process of the MFPP will have the following stages:

1. Evaluations every six months assessing enrollment appropriateness and MFPP capacity to increase enrollment.
2. Evaluations every six months examining MFPP effectiveness in reaching desired goals and objectives.
3. Feedback to MFPP administrators and providers concerning enrollment capacity and MFPP ability to change the design and/or implementation of the MFPP to improve performance toward meeting goals and objectives.
4. An evaluation at five years by an external agency to access MFPP overall progress and effectiveness.
5. Final measurements at five years in order to report successes and opportunities for improvement.

C. Project Goals and Objectives

Goal 1: Reduce number of unintended pregnancies for women at or below 185 percent FPL

Objectives

- Marketing MFPP to increase awareness of its availability and to effectively penetrate the eligible population to maximize enrollment
- Increased access to family planning services by expanding eligibility to 185 percent FPL
- Involvement of sufficient providers in MFPP for the provision of family planning services
- Develop marketing strategies targeting appropriate locations and populations for the MFPP
- Enroll 4,000 women of childbearing age who are at or below 185 percent FPL in the MFPP
- Assure access to family planning services by appropriate providers

Outcomes

- At year two a 1.5 percent reduction per 1,000 clients of unintended pregnancies as measured by MMIS and vital statistics data
- At year two enrollment of 4000 eligible women into MFPP
- At year five, a 5 percent reduction of unintended pregnancies over the five year duration of MFPP as measured by MMIS and vital statistics data

Goal 2: Decrease Medicaid delivery costs

Objectives

- Maximized awareness of MFPP
- Increased access to and availability of family planning services utilized by eligible population
- Educated providers on MFPP availability
- Brochures on MFPP distributed in provider offices along with other marketing strategies
- Implementation of a statewide public information campaign
- Enroll eligible women into MFPP
- Client compliance with family planning treatments
- Providers who serve to clients are guided by best practice guidelines

Outcomes

- A 90 percent client compliance with family planning treatments as measured by MMIS claims data
- A reduction in Medicaid delivery costs by 1.5 percent per 1,000 clients as measured by MMIS claims data and vital statistics

Goal 3: Decrease Medicaid first year costs

Objectives

- Provision of awareness of MFPP
- Sufficient enrollment of eligible women
- Maximized provision of family planning services by providers
- Enroll 4,000 women into MFPP
- Clients access available family planning services
- Insure compliance with family planning treatments

Outcome

- Decrease Medicaid first year costs by 1.5 percent per 1,000 clients as measured by MMIS claims data

Goal 4: Decrease incidence of babies born prematurely and/or with low birth weight

Objectives

- Women of childbearing age and under 185 percent FPL participating in MFPP
- Births averted by MFPP clients obtaining effective family planning services
- Monitoring of premature births and low birth weight babies by Vital Statistics and MMIS claims data

Outcome

- Medicaid and related programs will have a decrease in babies born prematurely and/or with low birth weights

Goal 5: Detection and treatment of STIs in MFPP clients

Objectives

- Adequate access to STI detection and treatment services for MFPP clients
- Provider awareness of MFPP's STI detection and treatment components
- MFPP clients receive STI detection procedures and treatment of any Chlamydia, Gonorrhea, and Syphilis infections
- MFPP clients receive laboratory testing for HIV, HSV, HPV and Hepatitis B&C
- Indicated referral to primary care providers for treatment of HIV, HSV, HPV and Hepatitis B and C as indicated
- Eligible clients receive HPV vaccination as indicated

Outcomes

- 100 percent of MFPP clients will receive STI detection and treatment services
- 100 percent of participating providers will be aware of the STI component of the MMFP
- 100 percent of clients found to have STI infection will be treated and/or referred to primary care providers for treatment
- 80 percent of clients eligible for HPV vaccine will receive all three necessary doses
- Outcome measurements assessed via MMIS claims data

Goal 6: High client and provider satisfaction with MFPP

Objectives

- A reliable and valid satisfaction survey will be developed and sent to MFPP clients and providers
- Return of satisfaction surveys maximized

Outcomes

- 100 percent of MFPP clients and providers will receive satisfaction surveys
- 65 percent of client surveys and 30 percent of provider surveys will be returned
- 80 percent of returned surveys will show a satisfied or very satisfied rating of the MFPP

The project evaluation process, by monitoring goals, objectives and resulting outcomes, will provide the capacity to assess MFPP success and opportunities for improvement in its ability to:

1. Effectively market program to targeted populations
2. Maximize enrollment of eligible potential clients for sufficient involvement in MFPP
3. Acquire sufficient providers for family planning services
4. Monitor client compliance with family planning care
5. Decrease unintentional pregnancies
6. Decrease delivery costs to Montana Medicaid
7. Decrease first year costs to Montana Medicaid
8. Detect and treat STIs
9. Refer clients to primary care treatment when indicated, and
10. Measure client and provider satisfaction in the MFPP

The ongoing monitoring will also allow for continuous feedback to MFPP administrators, Montana Medicaid, and providers to assure attainment of its goals and objectives. MFPP will increase care value by improving and increasing quality of care via providing family planning services to eligible women at or below 185 percent FPL and by decreasing Montana Medicaid costs by decreasing unintentional pregnancies and subsequent delivery and first year costs.

In addition, Montana Medicaid will provide quarterly expenditure reports using Form CMS-64, reporting on the number of individuals enrolled in MFPP. Annually, Montana Medicaid will provide CMS the average cost of a Medicaid funded birth and the number of actual births that occur with demonstration clients as well as the yearly number of clients in the MFPP.

Findings, both successes and opportunities for improvement, will be available for sharing with other States' family planning programs.

XII. Conclusion

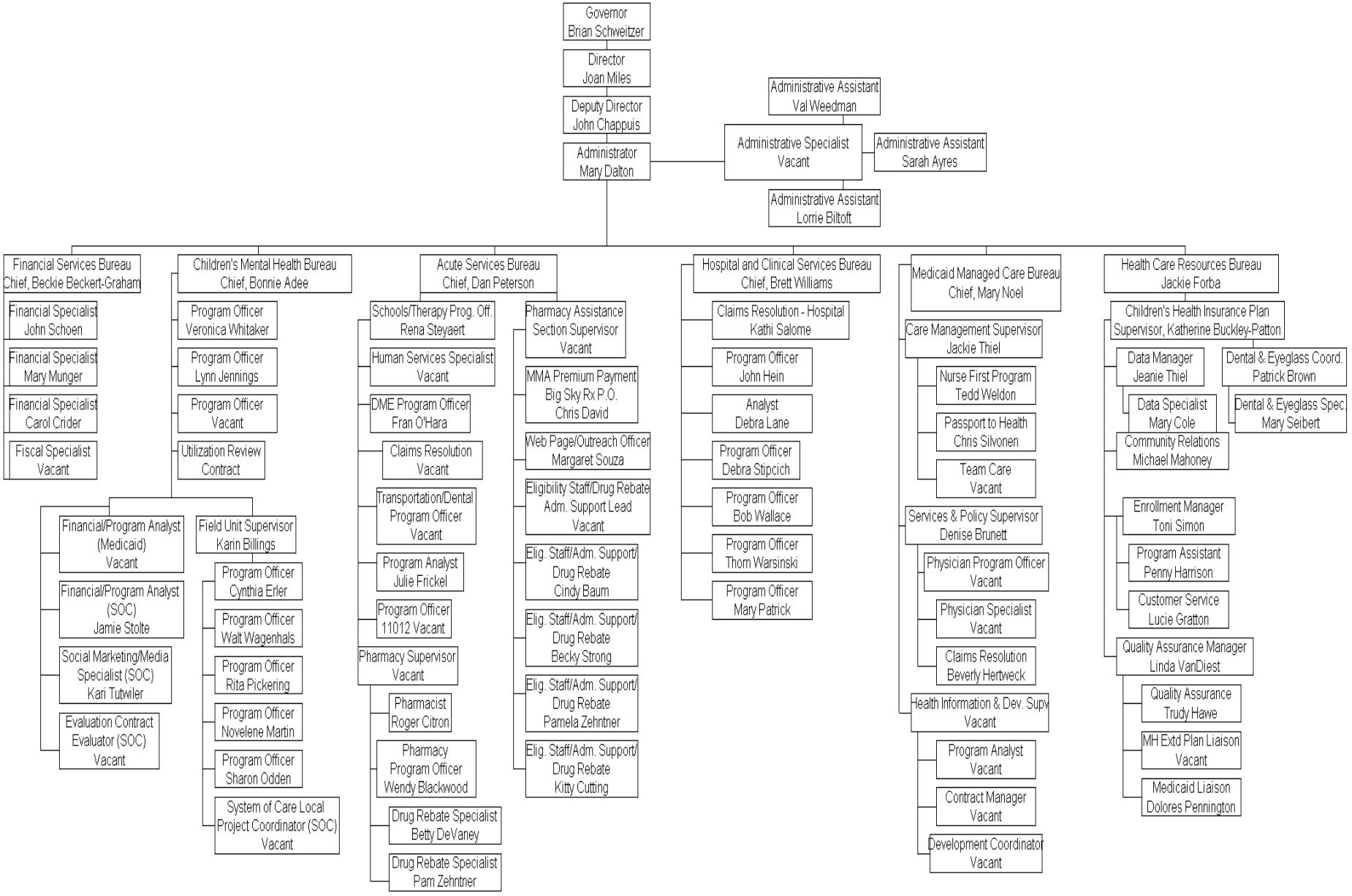
The MFPP will provide family planning services for women of childbearing age who are at or under 185 percent FPL and who would otherwise not qualify for Medicaid, resulting in improved health to Montana families. Family planning services will also result in averted births and subsequent savings of state and federal dollars.

ATTACHMENT A

MONTANA FAMILY PLANNING PROJECT

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
HEALTH RESOURCES DIVISION
ORGANIZATION CHART

HEALTH RESOUCES DIVISION ORGANIZATIONAL CHART



ATTACHMENT B

MONTANA FAMILY PLANNING PROJECT

PROCEDURE CODES FOR COVERED SERVICES

MONTANA FAMILY PLANNING PROJECT
PROCEDURE CODES FOR COVERED SERVICES

Procedure Code	Description
00840	Anesthesia for intraperitoneal procedures in lower abdomen
00851	Anesthesia for intraperitoneal proc in low abdomen incl lap; tubal lig
11975	Insertion, implantable contraceptive capsules
11976	Removal, implantable contraceptive capsules
11977	Removal with reinsertion, implantable contraceptive capsules
36415	Collection of venous blood by venipuncture
56501	Destruction of lesion(s), vulva; simple
56605	Biopsy of vulva or perineum; one lesion
56606	Biopsy of vulva or perineum; additional lesions
57170	Diaphragm or cervical cap fitting with instructions
57452	Colposcopy of the cervix including upper/adjacent vagina
57454	Colposcopy of the cervix with biopsy(s) of the cervix and endocervical curettage
57455	Colposcopy of the cervix with biopsy(s) of the cervix
57456	Colposcopy of the cervix with endocervical curettage
57460	Colposcopy of the cervix with loop electrode biopsy(s) of the cervix
57461	Colposcopy of the cervix with loop electrode conization of the cervix
57500	Biopsy, single or multiple, or local excision of lesion, with our without fulguration
57511	Cryocautery of cervix, initial or repeat
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), with cervical dilation
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)
80061	Lipid panel
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, keetones, leukocytes, nitrite pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis by dip stick or table reagent; automated, with microscopy
81002	Urinalysis by dip stick or tablet reagent; non-automated, without microscopy
81003	Urinalysis by dip stick or tablet reagent; automated, without microscopy
81005	Urinalysis; qualitative or semiquantitive, except immunoassays
81007	Urinalysis; bacteriuria screen, except by culture of dipstick
81015	Urinalysis; microscopic only
81020	Urinalysis; two or three glass test
81025	Urine pregnancy test, by visual color comparison methods
81099	Unlisted urinalysis procedure
82270	Blood, occult, by peroxidase activity
82465	Cholesterol, serum or whole blood, total
82947	Glucose; quantitative, blood
82950	Glucose; post glucose dose
82951	Glucose; tolerance test (GTT) three specimens
83001	Gonadotropin; follicle stimulating hormone (FSH)
83036	Hemoglobin; glycosylated (A1C)
83518	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; single step method

Procedure Code	Description
83898	Molecular diagnostics; amplification of patient nucleic acid, each nucleic acid sequence
84138	Pregnanetriol
84144	Progesterone
84146	Prolactin
84443	Thyroid stimulating hormone (TSH)
84591	Vitamin, not otherwise specified
84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hGC); qualitative
85009	Blood count; manual differential WBC count, buffy coat
85013	Blood count; spun microhematocrit
85014	Blood count; hematocrit (Hct)
85018	Blood count; hemoglobin (Hgb)
85025	Blood count; complete (CBC), automated (HGB, Hct, RBC, WBC and platelet count) and automated differential WBC count
85660	Sickling of RBC, reduction
86255	Fluorescent noninfectious agent antibody; screen, each antibody
86317	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86592	Syphilis test; qualitative (eg VDRL RPR ART)
86593	Syphilis test; quantitative
86689	Antibody; HTLV or HIV antibody, confirmatory test (eg Western Blot)
86694	Antibody; herpes simplex, non-specific type test
86695	Antibody; herpes simplex, type 1
86696	Antibody; herpes simplex, type 2
86701	Antibody; HIV-1
86702	Antibody; HIV-2
86703	Antibody; HIV-1 and HIV-2, single assay
86704	Hepatitis B core antibody (HBcAb); total
86705	Hepatitis B core antibody (HBcAb); IgM Antibody
86706	Hepatitis B surface antibody (HBsAb)
86707	Hepatitis Be antibody (HBeAb)
86762	Antibody; rubella
86781	Antibody; treponema pallidum, confirmatory test (eg FTA-abs)
86803	Hepatitis C antibody
86804	Hepatitis C antibody; confirmatory test (eg immunoblot)
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
87075	Culture, bacterial; any source except blood, anaerobic with isolation and presumptive identification of isolates
87076	Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate
87086	Culture, bacterial; quantitative colony count, urine
87088	Culture, bacterial; with isolation and presumptive identification of each isolate, urine
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail
87109	Culture, mycoplasma, any source
87110	Culture, chlamydia, any source
87164	Dark field examination, any source; includes specimen collection
87166	Dark field examination, any source; without collection

Procedure Code	Description
87205	Smear; primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87207	Smear, special stain for inclusion bodies or parasites
87210	Smear, primary source with interpretation; wet mount for infectious agents
87252	Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
87273	Infectious agent antigen detection by immunofluorescent technique; herpes simplex virus type 2
87274	Infectious agent antigen detection by immunofluorescent technique; herpes simplex virus type 1
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; chlamydia trachomatis
87340	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
87350	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis Be antigen (HBeAg)
87390	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1
87391	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-2
87449	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism
87480	Infectious agent detection by nucleic acid (DNA or RNA); candida species, direct probe technique
87481	Infectious agent detection by nucleic acid (DNA or RNA); candida species, amplified probe technique
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87492	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification
87510	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique
87511	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, amplified probe technique
87512	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, quantification
87515	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, direct probe technique
87516	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, amplified probe technique
87520	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, direct probe technique
87521	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, amplified probe technique
87528	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, firect probe technique
87529	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, amplified probe technique

Procedure Code	Description
87530	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, quantification
87531	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, direct probe technique
87532	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, amplified probe technique
87533	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, quantification
87534	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique
87535	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique
87536	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification
87537	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique
87538	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique
87539	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification
87590	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87592	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification
87620	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, direct probe technique
87621	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique
87622	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, quantification
87797	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism
87799	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreeing under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

Procedure Code	Description
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation
88160	Cytopathology, smears, any other source; screening and interpretation
88161	Cytopathology, smears, any other source; preparation, screening and interpretation
88162	Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
99201	Office or other outpatient visit for the evaluation and management of a new patient, with problem focused history, problem focused examination, and straightforward medical decision making.
99202	Office or other outpatient visit for the evaluation and management of a new patient, with expanded problem focused history, expanded problem focused examination, and straightforward medical decision making.
99203	Office or other outpatient visit for the evaluation and management of a new patient, with a detailed history, a detailed examination, and medical decision making of low complexity
99204	Office or other outpatient visit for the evaluation and management of a new patient, with a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity
99205	Office or other outpatient visit for the evaluation and management of a new patient, with a comprehensive history, comprehensive examination, and medical decision making of high complexity.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician, 5 minutes
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three: problem focused history, problem focused examination, and straightforward medical decision making.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three: expanded problem focused history, expanded problem focused examination, medical decision making of low complexity
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three: detailed history, detailed examination, medical decision making of moderate complexity
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three: comprehensive history, comprehensive examination, medical decision making of high complexity
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; late childhood (age 5

Procedure Code	Description
	through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; late childhood; (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; late childhood; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; late childhood; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; late childhood; 40-64 years
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

Procedure Code	Description
Appropriate HCPCS or National Drug Code	Antibiotics
	Cervical cap
	Cycle beads
	Depo-Provers
	Diaphragm
	Emergency contraceptive
	Female condoms
	Implanon
	Male latex and non-latex condoms
	Medication for vaginal infection
	Mirena, intrauterine device (IUD)
	Norplant
	Nuva Ring
	Oral contraceptive
	Ortho Evra
	Paragard
	Spermicides—contraceptive film and foam
	Sponge

ATTACHMENT C

MONTANA FAMILY PLANNING PROJECT

BUDGET NEUTRALITY WORKSHEET

Montana Family Planning Project Budget Neutrality Worksheet--Attachment C

Year		SY2005	SY2008	SY2009	SY2010	SY2011	SY2012	Total
Without Waiver								
Basic FP Services	Persons	6441	7456	7829	8220	8631	9063	
	Per Capita	$480	$556	$583	$613	$643	$675	
	Total	$3,091,680	$4,143,001	$4,567,752	$5,035,654	$5,551,804	$6,121,150	$25,419,362
Deliveries	Persons	4218	4685	4765	4846	4928	5012	
	Per Capita	$5,154	$9,815	$10,404	$11,028	$11,690	$13,115	
	Total	$21,739,572	$45,984,025	$49,572,224	$53,437,762	$57,608,553	$65,729,708	$272,332,271
First Year Costs	Persons	4254	4873	4951	5035	5116	5198	
	Per Capita	$6,353	$7,354	$7,722	$8,108	$8,514	$8,939	
	Total	$27,025,662	$35,837,942	$38,231,920	$40,825,928	$43,553,148	$46,462,491	$204,911,428
Total costs without waiver		$51,856,914	$85,964,968	$92,371,895	$99,299,343	$106,713,505	$118,313,349	$502,663,061
With Waiver								
Basic FP Services	Persons		7456	7829	8220	8631	8093	
	Per Capita		$556	$583	$613	$643	$675	
	Total		$4,143,001	$4,567,752	$5,035,654	$5,551,804	$5,466,012	$24,764,224
Deliveries	Persons		4685	4479	4555	4628	4702	
	Per Capita		$9,815	$10,404	$11,028	$11,690	$13,115	
	Total		$45,983,537	$46,597,880	$50,233,412	$54,099,415	$61,665,014	$258,579,259
First Year Costs	Persons		4873	4663	4743	4823	4905	
	Per Capita		$7,354	$7,722	$8,108	$8,514	$8,939	
	Total		$35,837,942	$36,011,759	$38,455,131	$41,064,357	$43,850,566	$195,219,755
Expanded FP	Persons		3000	4000	4000	4000	4000	
	Per Capita		$556	$583	$613	$643	$675	
	Total		$1,666,980	$2,333,760	$2,450,440	$2,572,960	$2,701,600	$11,725,740
Total With Waiver Costs			$87,631,461	$89,511,151	$96,174,637	$103,288,537	$113,683,192	$490,288,978
Administrative Costs: Systems			$100,000					
Administrative Costs: Public Awareness			$25,000	$25,000	$25,000	$25,000	$25,000	
Administrative Costs: Evaluation			$25,000	$25,000	$25,000	$25,000	$25,000	
Eligibility Administration: one 1 FTE			$35,347	$35,392	$36,277	$37,184	$38,113	
Total With Waiver			$87,816,808	$89,596,543	$96,260,914	$103,375,721	$113,771,305	$490,821,291
Difference: W/out Waiver and W/Waiver Costs			($1,851,840)	$2,775,353	$3,038,429	$3,337,784	$4,542,043	$11,841,770